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Issue Date: 14 June 2007

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In the Matter of

J.D.T.[1]
Claimant
v.
INDUSTRIAL MARINE SERVICE, INC.;
AIU INSURANCE CO.
Employer/Carrier
And
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest
……..

Case No. 2006 LHC 01096
OWCP No. 6-193508

Decision and Order

This matter arises pursuant to a claim for benefits filed under the Longshore Act by J.D.T. a resident of Alabama. Claimant injured his hip, neck, buttocks, and back on January 2, 2004, while working as a sandblasting painter in the Portsmouth Naval Shipyard. Working in a large tank aboard a ship, Claimant stepped on a piece of grating which slipped, causing him to fall six to eight feet onto next level of grating below. Tr. 13-14; 26-27. In this proceeding, compensation is not in issue. Claimant is seeking medical benefits only; specifically, a sacroiliac fusion. Tr. 8. Employer insists that the fusion is not necessary.

Following the accident, Claimant's carried him out of the tank, Tr. 29, and Claimant asked to go to the hospital. Instead, he was driven back to his motel room and delivered to his wife who then drove him to Jacksonville where he went to St. Luke's Hospital. Tr. 14; 27-28, 30-31. Since then, Claimant has experienced radiating pain down the right leg that has limited his ability to stand, walk, or drive, and has made his life "a living hell." Tr. 15-16, 18. He testified that injection treatments have provided only temporary relief, Tr. 17-18, 21, and his physician

[1] Effective August 1, 2006, the U.S. Department of Labor implemented a policy to avoid using claimants' names in the caption or body of any Black Lung or Longshore decision or order. In lieu of identifying the claimant by name, the policy requires the use of the claimant's initials.

has recommended a sacroiliac fusion. Tr. 18-19. When told by Employer that Dr. Graham Smith is the only physician in Jacksonville who recommends such a procedure, Tr. 20, he testified that he understands that the procedure is very serious; but no other physician has offered any type of treatment that would improve his back condition. Tr. 24.

Medical Evidence

Claimant visited Dr. Arnold Graham Smith, an orthopedic surgeon, on June 16, 2004. Dr. Graham Smith took Claimant's accident, medical, and pain symptom histories, performed a physical examination, and reviewed a lumbar x-ray which he reported was "essentially normal." CX 1. Dr. Graham Smith suspected probable discogenic injury causing right sciatica or possible sacroiliac injury, and he recommended a lumbar spine MRI. CX 1. The MRI was performed, and Dr. Graham Smith interpreted it on July 14, 2004 as "essentially normal." Claimant's pain symptoms continued, however, and Dr. Graham Smith recommended a sacroiliac arthrogram and block for diagnostic purposes. CX 1. On June 14, 2005, Claimant reported to Dr. Graham Smith that pain was radiating down both legs which led him to suspect that Claimant may have not only a sacroiliac injury but an "annular fissure somewhere." Dr. Graham Smith expressed concern that Claimant had been under his care for a year and he still had no definitive diagnosis, and, therefore, recommended a discogram at L3/L4, L4/L5, and L5/S1. By November 8, 2005, Claimant reported to Dr. Graham Smith that Dr. Rogozinski had conducted an IME and had indicated that Claimant may have suffered some nerve damage, an impression with which Dr. Graham Smith disagreed. CX 1. On December 21, 2005, Dr. Graham Smith reported that he had reached a "firm" diagnosis and recommended sacroiliac joint fusion to treat Claimant's condition. CX 1.

In a letter dated February 24, 2006, Dr. Graham Smith noted that Dr. Rogozinski diagnosed right sacroiliac joint sprain/strain but opined that Claimant did not exhibit the "classic" pain pattern for right sacroiliac pain. Dr. Graham Smith observed that he would: "love to know what the classic pain pattern is because they are all completely different." In Dr. Graham Smith's opinion, Claimant's pain which radiates down the leg is important because it is commonly associated with S1 nerve root irritation and the pain in the groin is a feature of pelvic instability not necessarily a problem in the hip. Dr. Graham Smith had no objection to a bone scan or an MRI of the hip as recommended by Dr. Rogozinski, but he noted that the reports of improvement in Claimant's pain following sacroiliac injection: "gave me adequate grounds to believe that sacroiliac joint

fusion will be required in the future." CX 1. As such, on August 7, 2006, Dr. Graham Smith, reporting that Dr. Solis believes Claimant's foot pain originates with an irritated sciatic nerve, again recommended the sacroiliac joint fusion. CX 1.

Dr. Abraham Rogozinski, an orthopedic surgeon, was deposed on October 25, 2006. His deposition is admitted into evidence as EX 2. By letter dates October 24, 2005, he reported that he reviewed Claimant's medical records, the history of his present illness, and performed an IME. Dr. Rogozinski noted that an October 24, 2005, x-ray revealed, "mild" degenerative changes in the left sacroiliac joint, a July 1, 2004 MRI revealed well hydrated discs with facet arthrosis at L4/L5, L5/S1, a July 15, 2005 discogram revealed an annular tear at L5/S1 extending leftward, and an August 4, 2005, CT Scan showed L4/ L5, L5/S1, and sacroiliac degenerative arthritis, and right S1 joint leakage. Among his seven specific diagnoses, Dr. Rogozinski included L4-S1 facet degenerative arthritis, L5/S1 internal deranged disk, and right sacroiliac sprain/strain. Dr. Rogozinski recommended against surgery for a sacroiliac fusion at the time, and recommended instead a neurological evaluation, additional MRI studies, a bone scan, and additional facet blocks.

At his deposition, Dr. Rogozinski reviewed his physical findings, his diagnoses, and his recommendations. Dep. at 9-11. He explained that Claimant had a significant, but temporary, response to prior facet block injections, with a 90% reported improvement in September, 2004; however, the type of response he experienced did not establish a "strong indication to consider the sacroiliac joint as the primary source of pain." Dep. at 13. Dr. Rogozinski further observed he did not believe that the sacroiliac was the source of Claimant's symptoms because the actual pattern of his pain was: "not localized to the sacroiliac joint….the radiation of pain to the right groin and hip, which is not typical for sacroiliac pain. And the fact that on numerous studies, the right sacroiliac joint appears normal." Dep. at 13.

Dr. Rogozinski was aware that Dr. Hartwig conducted the neurological examination he had recommended, and he was aware that Claimant had been treating with Dr. Revels in Alabama, and that Dr. Revels recommended further diagnostic studies. Dep. at 16. While Employer attached reports by Dr. Revels to Dr. Rogozinski's deposition, Claimant did not offer into evidence any additional information about his care or treatment by Dr. Revels. Dr. Rogozinski testified that he still would like to see the results of a bone scan and an MRI of Claimant's hip, but if the problem was not intrinsic to the hip, the diagnoses are right ischium

and L4/L5, L5/S1 facet degenerative arthritis, degenerative disc at L5/S1, and a possible right sacroiliac sprain. Dep. at 19. He does not believe Claimant has reached MMI. Dep. at 19.

Turning specifically to question of treatment, Dr. Rogozinsky opined that a right sacroiliac fusion is not medically indicated and is not necessary at this time. Dep. at 20. Dr. Rogozinski testified that he has performed SI joint fusions and has recommended them, Dep. at 20-21, but he does not believe it is appropriate for Claimant, because he believes there is a lack of objective indications of injury to the right sacroiliac joint. Dep. at 20-21. Dr. Rogozinski testified that the bone scan, the MRI, and the repeat facet injections he recommended had not been performed, Dep. at 24; however, he did believe he had sufficient information to recommend against the SI fusion. Dep. at 26. Dr. Rogozinski noted that the facet blocks could be both diagnostic and therapeutic. Dep. at 26. He noted that Dr. Graham Smith, in contrast, saw no need for any further nerve conduction studies or blocks. Dep. at 28.

Dr. Tim Revel and Dr. Bruce Hartwig, a neurologist, evaluated claimant's cervical symptoms, and Dr. Hartwig also evaluated Claimant's "sustained ankle clonus" which he opined could be attributable to cervical spondylosis most prominently at C5/C6. Both Dr. Hartwig, and later Dr. Rogozinski, Dep. at 9,15,18, opined that the ankle clonus was not related to Claimant's back problem.

Conclusions of Law

I.

Section 20 Presumption

Claimant contends in his post-hearing brief that the Section 20 presumption applies to a determination of the necessity and reasonableness of the sacroiliac fusion recommended by Dr. Graham Smith, and once the presumption is triggered, Employer must demonstrate that the proposed treatment is neither reasonable nor necessary.[2] Employer notes its agreement that this claim involves a compensable

[2] Claimant was initially represented in this matter by Mr. Douglas Daze. At the hearing, Mr. Daze made no closing statement, and stated he would prefer to brief the matter after receipt of Dr. Rogozinski's post-hearing deposition, and it was agreed by the parties that briefs would be filed by November 30, 2006. Tr. 35, 36-37. Employer submitted its brief on November 29, 2006. No brief was filed on Claimant's behalf, and Claimant subsequently dismissed Mr. Daze as his counsel. Claimant retained new counsel who advised that he had attempted unsuccessfully to contact Mr. Daze to obtain Claimant's file. To facilitate a resolution, a transcribed post-hearing conference was deemed advisable to consider the matter; and efforts were made to contact Mr. Daze, including a message left on his answering machine, advising him that a conference was needed and asking him to reply. Mr. Daze did not respond, however, and a telephone conference was, thereafter, scheduled for March 8, 2007, and convened as scheduled. Claimant's new counsel and Employer agreed that, in lieu of obtaining Claimant's file from

injury, but it insists the presumption does not apply because the only issue is the necessity and reasonableness of a specific medical procedure flowing from a derivative claim for medical benefits. In the Employer's view, that decision can only be made after a review of the record considered as a whole, with the burden of proof and persuasion resting upon Claimant in accordance with Director v. Greenwich Collieries, 512 U.S. 267 (1994).

While the presumption applies generally to a claim for medical benefits, Employer is correct in its analysis that Claimant is not afforded the benefit of a Section 20(a) presumption for purposes of establishing the reasonableness of medical treatment under Section 7 of the Act. Neither Section 7 of the Act nor the regulations explicitly assigns the burden of proof, but the Board has determined that a claimant is not relieved of the burden of proving the elements of a claim for medical benefits, and must establish the necessity of treatment rendered for his work related injury. *See generally,* Schoen v. U.S. Chamber of Commerce, 30 BRBS 112 (1996); Wheeler v. Interocean Stevedoring, Inc., 21 BRBS 33 (1988); Ballesteros v. Willamette Western Corp., 20 BRBS 184 (1988).

II.
Appropriate Medical Treatment
A.
Community Standards

Citing Ballestero and the regulations at 20 CFR 702.401, Employer argues further that the medical care must be recognized as appropriate by the medical profession for the care and treatment of the injury or the disease. At the hearing, Employer suggested that the sacroiliac fusion recommended by Dr. Graham Smith was not recognized as appropriate by the medical profession for the care and treatment of the injury or the disease, and that Dr. Graham Smith was the only physician "in town" who even recommended the procedure. Tr. 20. Yet, Dr. Graham Smith's recommendation was not as radical as Employer suggested. Dr. Rogozinski, at his deposition, testified that he has, on occasion, recommended sacroiliac fusions, Dep. at 20, and has performed them, Dep. at 22; and he confirmed that the medical literature indicates that the procedure provides reasonable relief in appropriately selected patients. Dep. at 21. Consequently, Employer's argument to the contrary notwithstanding, the record shows that the

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his former counsel, Employer would provide Claimant with a copy of the evidence adduced at the hearing; and Claimant's new counsel was afforded thirty days to file a brief on Claimant's behalf. Claimant's brief was, thereafter, filed on April 3, 2007.

sacroiliac fusion procedure is recognized as appropriate by the medical profession for the care and treatment of injury or disease.

Appropriate Medical Treatment
B.
Individual Patient

In Dr. Rogozinski's opinion, however, Claimant is not an appropriate patient to undergo the procedure; and thus he raises a separate issue which really lies at the center of this controversy. Because Dr. Graham Smith, Claimant's treating physician, has diagnosed an injury to the sacroiliac joint which he has treated over time with conservative modalities with only limited or temporary success, he now considers the fusion he recommends necessary and appropriate treatment for Claimant's condition. Dr. Rogozinski, however, believes that the sacroiliac joint is not the source of Claimant's symptoms, and it follows as a consequence for him, that a sacroiliac fusion would constitute an inappropriate procedure. He recommends instead further clinical testing to isolate the source of the problem. Until then, he offers Claimant no actual treatment recommendation beyond the diagnostic facet blocks which he observed can have a therapeutic effect. Both Dr. Rogozinski and Dr. Graham Smith are highly qualified Board-certified orthopedic surgeons, and the evidentiary weight accorded their respective opinions can not, on this record, be differentiated on the basis of their credentials or expertise.

The record shows that both Dr. Rogozinski and Dr. Graham Smith have reviewed Claimant's accident and pain symptom histories, examined him, and evaluated x-rays and other clinical and diagnostic data. Dr. Rogozinski disagreed with Dr. Graham Smith's diagnosis because an MRI was essentially normal, and, in his view, Claimant did not otherwise manifest what he described as the "classic pattern" for sacroiliac pain. The type of response Claimant experienced to facet block injection did not, in Dr. Rogozinski's opinion, establish a "strong indication to consider the sacroiliac joint as the primary source of pain." He explained that he did not believe that the sacroiliac was the source of Claimant's symptoms because the actual pattern of his pain was: "not localized to the sacroiliac joint….the radiation of pain to the right groin and hip, which is not typical for sacroiliac pain. And the fact that on numerous studies, the right sacroiliac joint appears normal."

Dr. Graham Smith reviewed Dr. Rogozinski's comments and scoffed at the notion that there is such a thing as a "classic" pattern for right sacroiliac pain. In his opinion, patients with sacrolilliac pain present with different symptom patterns and that pain radiating down the leg is commonly associated with S1 nerve root

irritation due to the joint injury while pain in the groin is a feature of pelvic girdle instability not necessarily a hip problem. Dr. Graham Smith expressed his criticism of Dr. Rogozinski's evaluation in his letter dated January 24, 2006.

The record shows that Dr. Rogozinski was deposed on October 25, 2006. He indicated that he was aware of Dr. Graham Smith's comments about his recommendations, Dep. at 27, and he mentioned twice again that Claimant did not present with the "classic" pain pattern of sacroiliac disease, because Claimant's pain radiated into his leg, groin and hip. Dep. at 11 and 13. He did not, however, specifically address Dr. Graham Smith's contention that SI joint injury is commonly associated with S1 nerve root irritation and radiating pain, nor did he comment on Dr. Graham Smith's observation that groin pain is a feature of pelvic girdle instability not necessarily a hip problem.

Dr. Rogozinski did note that the medical literature supports sacroiliac fusion for "appropriately selected patients;" but except to opine that Claimant was not appropriately selected, he did not mention the physiologic or clinical findings, if any, identified in the literature as the benchmarks or classic medical criteria for deciding which patient is appropriate for the fusion and which is not. In summary, if the medical literature supported a "classic" pain pattern of sacroiliac disease, Dr. Rogozinski did not cite it in refutation of Dr. Graham Smith's professional challenge that he: "would love to know what the classic pattern is…." Further, although Dr. Rogozinski opined that the factors Dr. Graham Smith relied upon, including Claimant's "pain complex" and response to sacroiliac and facet blocks, were insufficient "to establish the right sacroiliac joint as a source of the pain," Dr. Rogozinski nevertheless diagnosed, among other conditions, "right sacroiliac sprain/strain," and thus confirmed Dr. Graham Smith's diagnosis.

C.
Additional Testing

Dr. Rogozinski did, of course, recommend a bone scan, a hip MRI, and additional facet blocks while Dr. Graham Smith deemed the additional diagnostic tests Dr. Rogozinski recommended a waste of the carrier's money. Under such circumstances, the party who deems a medical test necessary ordinarily is the party expected to take appropriate action to obtain it. Dr. Graham Smith did not deem further tests necessary, but Dr. Rogozinski thought they would be useful. Yet, the tests were not administered.

The record shows that Dr. Graham Smith had "no objection to [Claimant] undergoing bone scan and MRI of the hip…," and there is no indication in this

record that Claimant declined any request by the Employer that he undergo additional testing. It thus appears that Dr. Rogozinski either failed simply to schedule them or the Carrier declined to approve his recommendation. In either eventuality, Dr. Graham Smith is confident he has sufficient information to support his treatment plan, while Dr. Rogozinski believes further tests may, if administered, provide indications that the origin of Claimant's pain emanates from a source other the SI joint. The absence of the test data Dr. Rogozinski seeks, however, does not diminish the diagnosis formulated by Dr. Graham Smith, particularly under circumstances in which he deems the missing data superfluous and relies instead upon alternative diagnostic indications to render a diagnosis of sacroiliac sprain/strain with which Dr. Rogozinski ultimately agrees.

D.
Treating Physician's Treatment Plan

The record shows that Dr. Graham Smith, as Claimant's treating physician, did not hastily contemplate surgery as a first resort but carefully formulated his diagnosis and treatment recommendations during the period of a year while he explored more conservative treatment modalities which afforded only limited effectiveness. Over time, it was Claimant's feedback of temporary, but significant, improvement from sacroiliac joint injections which persuaded Dr. Graham Smith that the SI fusion is reasonable and necessary for the care and treatment of Claimant's injuries.

Under similar circumstances, the Board has held that it is proper to give more weight to the opinion of a treating physician, like Dr. Graham Smith, who was able to provide an explanation for a Claimant's pain than to a doctor, like Dr. Rogozinski, who could offer several possible theoretical reasons but could not relate the possible causes specifically to the Claimant. *See*, Cotton v. Army & Air Force Exchange Services, 34 BRBS 88 (2000). Application of the Board's rationale in Cotton seems particularly appropriate under circumstances such as those presented here in which it appears that Employer's expert deemed more testing desirable but either failed to schedule it or was unable to secure carrier approval to obtain it. Consequently, I have accorded greater weight to Dr. Graham Smith's opinion that the SI fusion is appropriate for Claimant's right sacroiliac sprain/strain, which both he and Dr. Rogozinski diagnosed, than the contrary recommendation by Dr. Rogozinski that such treatment should be withheld.

III.
Greenwich Collieries

Finally, Employer cites the Supreme Court's decision in Director v. Greenwich Collieries in support of its argument that since two equally qualified physician's reach diametrically opposing opinions regarding the propriety of a sacroiliac fusion for this Claimant, the evidence must be in equipoise; and since Claimant has the burden of proof under Director v. Greenwich Collieries, his claim for medical benefits which include that procedure must be denied. Employer has correctly described the burden of proof as mandated by the Court in Greenwich Collieries, but Greenwich Collieries is not applicable.

The evidence here is not in equipoise merely because two physicians reach different conclusions about the surgery one of them recommends. As discussed above, in addition to Dr. Graham Smith's status as Claimant's treating physician, which is a factor in weighing expert medical opinion evidence, Amos v. Director, 153 F.3d 1051 (1998), amended, 164 F.3d 480, (9th Cir. 1999), cert. denied, 528 U.S. 809 (1999); Monta v. Navy Exchange Service Command, 39 BRBS 104 (2005); *see also*, Downs v. Director, 152 F.3d 924, (9th Cir. 1998)(July 10, 1998), several other factors, including the "classic" pain pattern issue discussed above, the diagnosis of sacroiliac sprain/strain by both physicians, and Dr. Graham Smith's consideration of not only the negative MRI but his experience in providing actual care and treatment to Claimant over an extended period of time, sorting out what proved ineffective and what modalities provided relief, if only temporarily, considered together and separately, have persuaded me that Dr. Graham Smith's opinion is entitled to greater evidentiary weight than the contrary opinion of Dr. Rogozinski. The record further shows that a sacroiliac joint fusion is recognized as appropriate by the medical profession for the care and treatment of injury or disease; that the treating physician deems it appropriate for Claimant's injury; and that the medical procedure is related to the injury. These are factors which satisfy Claimant's burden of proof under Greenwich Collieries and are factors indicative of Longshore Act coverage. Ballesteros v. Willamette Western Corp., 20 BRBS 184 (1988). *See also* 20 C.F.R. §702.402.

For all of the foregoing reasons, the sacroiliac joint fusion recommended by Dr. Graham Smith is a medical treatment option that is available to Claimant. Indeed, the Board has held that when a Claimant is presented with valid medical options, the decision should be left with the Claimant to choose between them, and Employer is liable for the option he chooses. Monta v. Navy Exchange Service

Command, 39 BRBS 104 (2005); Caudill v. Sea Tac Alaska Shipbuilding, 25 BRBS 92 (1991), aff'd mem. sub. nom. Sea Tac Alaska Shipbuilding v. Director, 8 F.3d 29 (1993). Accordingly:

ORDER

IT IS ORDERED that Employer provide Claimant such reasonable and necessary medical care and treatment, including but limited to a sacroiliac joint fusion surgery, for the injuries Claimant sustained at work on January 2, 2004.

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Stuart A. Levin
Administrative Law Judge